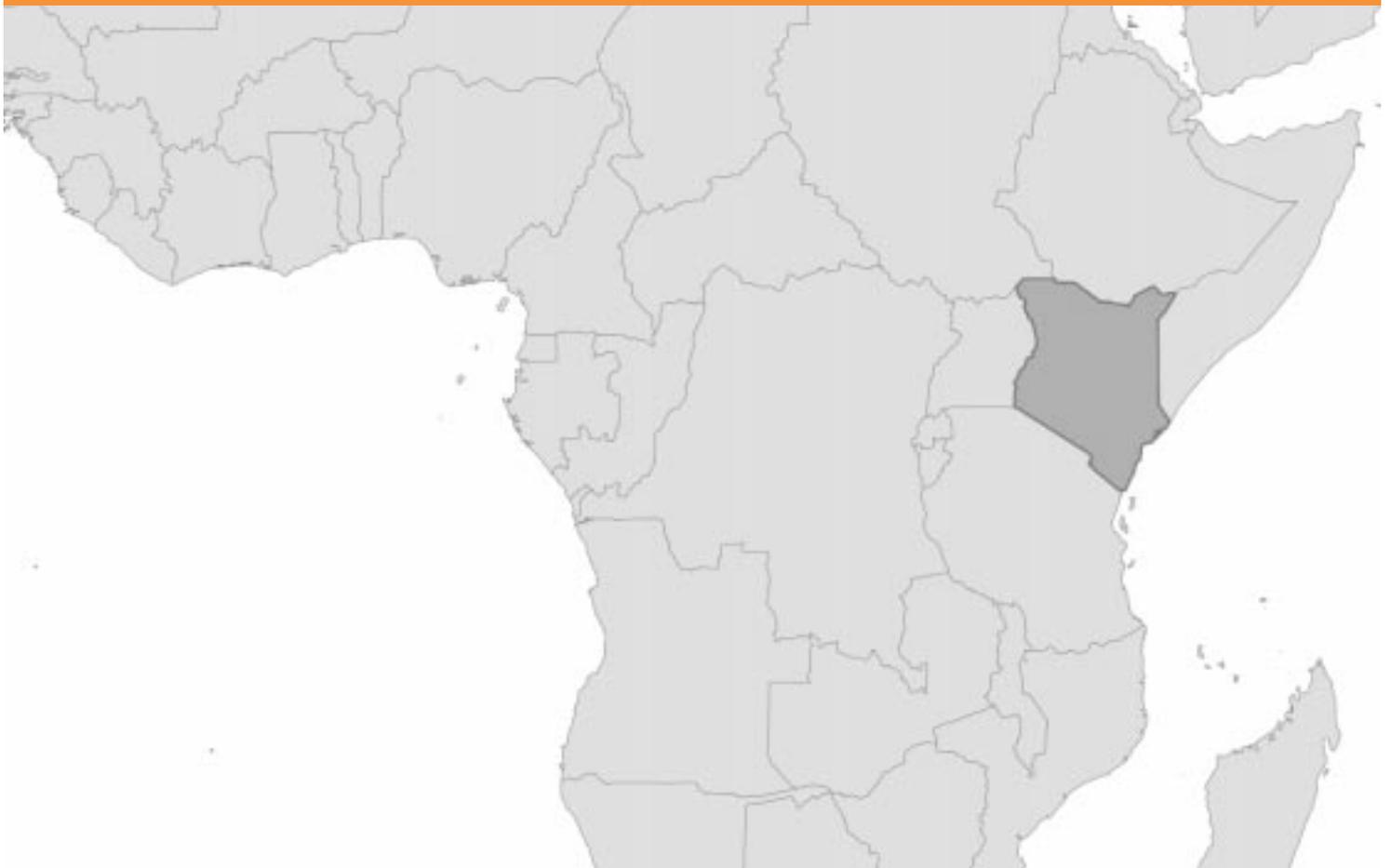


THE IMPACT OF THE GLOBAL GAG RULE IN KENYA

ACCESS
DENIED





THE GLOBAL GAG RULE has closed clinics, curtailed family planning and maternal and child health care services, and weakened the collective Kenyan NGO response to HIV/AIDS.

THE IMPACT OF THE GLOBAL GAG RULE IN KENYA

EXECUTIVE SUMMARY

The first African organization to advance women's reproductive health and provide contraceptive services began its work in Kenya 40 years ago. Kenya was the first African country to establish a population policy and a national family planning program, both in 1967. Despite these early accomplishments however, 24 percent of married women in Kenya who want to stop or delay their childbearing today are not using family planning. Meanwhile, rates of maternal and infant mortality remain high and an estimated one-third of pregnancy-related deaths are due to unsafe abortion. Abortion is illegal in Kenya (except to save the woman's life), yet the practice is widespread, reflecting both the unmet need for family planning and the lengths to which women will go to control their fertility.

The Global Gag Rule* has eroded long-established family planning services in Kenya. The country's two leading reproductive health organizations refused the restrictions and subsequently lost U.S. family planning funds. As a result, they are prevented from participating in a large-scale integrated health care program funded by the U.S. Agency for International Development (USAID), which curtails the effectiveness and reach of the program. Five family planning clinics have been forced to close, and **women's access to contraception, gynecologic and obstetric care, screening and treatment for sexually transmitted infections (STIs), and voluntary counseling and testing for HIV/AIDS has been severely disrupted**. Ironically, following a free election in Kenya supported by the United States, those nongovernmental organizations (NGOs) that have agreed to the terms of the Global Gag Rule are silenced from participating in the widely expected democratic debate about reforming the country's restrictive abortion law.

REPRODUCTIVE HEALTH IN KENYA

Similar to every country in sub-Saharan Africa, Kenya is in dire need of family planning assistance. Of Kenya's 31.1 million people, fully one-quarter subsist on less than \$1 a day. Forty-four percent of the Kenyan population is 14 years old or younger,¹ signaling an increasing demand for reproductive health services in the near future. Eighty percent of Kenya's population resides in rural areas, making the delivery of health services more difficult.

Public spending on health care is less than U.S. \$6 per person annually and the health infrastructure is deteriorating. Seventy-eight percent of the Kenyan annual budget comes from international donor assistance. On average, a single physician serves 7,500 people. Most doctors reside in urban centers — where only 20 percent of the population is located. The majority of Kenyans depend for their health care on nurses, nurse-midwives and traditional healers.

Average life expectancy at birth is 48 years — one of the lowest such figures in the region. The infant mortality rate is 74 deaths per 1,000 births.¹ Malaria, endemic in most parts of Kenya, poses a major threat to child health and survival.² The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria estimates that 34,000 children die each year from malaria, and 4,000 babies are born with low birth weight due to maternal malaria infection.³

Childbirth remains a risky endeavor for many Kenyan women, with a maternal mortality ratio of 1,300 maternal deaths per 100,000 live births.⁴ Twenty-seven percent of all deaths for women aged 15 to 49 are pregnancy-related.² Almost half (46 percent) of Kenyan women give birth before the age of 20.⁵ Although access to prenatal care is quite high in Kenya, close to half of all births (44 percent) are not attended by skilled personnel.²

Average family size in Kenya has declined dramatically from eight children in 1980 to four today. According to a 1998 national health survey, 63 percent of the potential demand for family planning was being satisfied. Thirty-nine percent of married women use some form of contraception, with most choosing a modern method. Although government facilities are a primary source of family planning services, with 58 percent of Kenyan women using contraception obtained from government hospitals and clinics, there has been a major shift away from public facilities since 1993 — a decline of nearly 70 percent over a five-year period. Private sources provided 42 percent of contraceptive services in 1998, an indication of patient preference for care provided by NGO clinics and other private providers.²

* Also known as the Mexico City Policy, the Global Gag Rule prohibits U.S. assistance for family planning from being provided to foreign nongovernmental organizations (NGOs) that use funding from any other source to perform abortion in cases other than a threat to the life of the woman, rape, or incest; to provide counseling and referral for abortion; or to lobby to make abortion legal or more available in their own country. Assistance is defined to include not just funds but the provision of technical assistance, customized training, and commodities, including contraceptive supplies. The only requirement imposed on U.S. NGOs by the Global Gag Rule is the responsibility to enforce the policy on their foreign NGO partners. The Global Gag Rule does not apply to foreign governments receiving U.S. family planning assistance. For the full text of the Mexico City Policy, see USAID, Contract Information Bulletin, "Restoration of the Mexico City Policy - White House Memorandum for the Acting Administrator of the U.S. Agency for International Development (Revised)," [CIB 01-08 (R)], 29 March 2001. Available on the USAID website at http://www.usaid.gov/procurement_bus_opp/procurement/cib0108r.pdf.

There remains, however, a significant unmet need for family planning, especially in rural areas. Overall, **24 percent of married women in Kenya have an unmet need for contraception.** In 1993, unmet need was 34 percent. Unmet need is much greater among rural women (26 percent) than urban women (17 percent). Consequently, 48 percent of recent births were reported by women to be unwanted or mistimed (i.e., wanted later). The need for expanded access to family planning and reproductive health care is especially critical among adolescents. Among ages 15 to 19, contraceptive use is very low due to this age group's low exposure to family planning information and services. Similarly, Kenyans younger than 20 demonstrate a lack of understanding about key aspects of the AIDS epidemic — they know little about sexually transmitted infections and where to obtain condoms, and are more likely to hold misconceptions about modes of HIV transmission.²

Fifteen percent of all adults (aged 15 to 49) are infected with HIV/AIDS, putting Kenya among the African countries hardest-hit by the epidemic. An estimated 3.1 million people are currently living with HIV/AIDS. According to a joint report by UNAIDS, USAID and UNICEF, there were an estimated 890,000 AIDS orphans in Kenya as of 2001; that number is expected to rise to over 1.5 million by 2010.⁶ In addition, the epidemic has resulted in exponential growth of the number of tuberculosis (TB) infections in the country. Normally latent in approximately half the population, the combination with the HIV/AIDS virus has tripled the number of active adult TB infections,⁶ straining the already weak health care infrastructure.

HIV/AIDS is a major reproductive health issue in Kenya and the rest of Africa. In every sub-Saharan African country, more women than men are infected with HIV. **In Kenya, currently 60 percent of those living with HIV/AIDS are women.**⁷ Young women aged 15-24 are more than twice as likely as men within the same age category to be infected.⁶ A number of socio-economic and cultural factors contribute to the disproportionate impact of HIV/AIDS on women. Early sexual initiation of girls, the large age differential between men and women in sexual relationships, rape and other forms of gender-based violence and exploitation occur frequently in Kenya.⁷

In Nairobi about 60 percent of all acute gynecological hospital admissions are due to complications from unsafe abortion, such as perforation of the uterus or infection caused by unsterilized equipment.

Rates of illegal and unsafe abortion are high among Kenyan women of all ages and socio-cultural and economic backgrounds in both rural and urban areas.⁸ Unsafe or failed abortions are the cause of an estimated one-third of maternal deaths each year in Kenya.⁹ The incidence of unsafe abortion reflects women's determination to control their fertility and underscores their unmet need for family planning services. In Nairobi about 60 percent of all acute gynecological hospital admissions are due to complications from unsafe abortion, such as perforation of the uterus or infection caused by unsterilized equipment.¹⁰ In many cases, women die following unsafe abortion due to their lack of access to adequate medical treatment and post-abortion care.⁵ Public debate about abortion has increased in recent years, yet the previous government was reticent to address the issue for a variety of reasons. A constitutional review process undertaken by the new government is currently bringing the issue to the fore.

U.S. ASSISTANCE

The United States is Kenya's leading population and health donor. The primary health objective of USAID in Kenya is to "reduce fertility and the risk of HIV/AIDS transmission through integrated family planning and health services."⁵ Toward this end, USAID provides technical and financial support to Kenya's national programs in family planning, HIV/AIDS and child survival, which is channeled through NGOs and the Ministry of Health.¹¹ USAID is one of the few major donors that directly funds NGOs, thereby investing in the capacity of Kenyan organizations and their staff to provide quality health care. Other donors direct their population and health assistance to the Kenyan government, which in turn may reach NGOs depending on the source and type of assistance. For example, the United Kingdom's Department for International Development (DFID) — USAID's British counterpart — supplies the Ministry of Health with condoms and other contraceptives, a portion of which is steered to Kenyan NGOs.

Starting in 2001, USAID ramped up its HIV/AIDS effort appreciably, identifying several countries as high priority for greater HIV/AIDS funding. Kenya was deemed a “rapid scale-up” HIV/AIDS country, along with Cambodia, Uganda and Zambia. This designation translated into a wave of new HIV/AIDS funding for Kenya — U.S. \$17.5 million in fiscal year 2002, up from \$11.5 million in 2001. Prevention and care efforts intensified throughout the country. New voluntary counseling and testing (VCT) sites were established in existing health clinics, sales of socially marketed condoms increased, and community-based care programs for those with HIV/AIDS expanded. The influx of new HIV/AIDS monies enabled USAID to boost national efforts to prevent mother-to-child transmission.

Simultaneously, USAID undertook a major shift in its approach to financing family planning activities. In March 2001, USAID launched the AMKENI Project, a five-year, \$16 million package of family planning, reproductive health and child survival services. The lead NGO managing AMKENI — which means “new awakening” in Kiswahili — is New York-based EngenderHealth, a reproductive health NGO that has worked in Kenya for more than 20 years. As initially conceived, Kenyan organizations and the Ministry of Health would take the lead in implementing the project at the local level, through both private and public clinics.

The Family Planning Association of Kenya (FPAK) and Marie Stopes International Kenya (MSI Kenya) were two NGOs expected to play leading roles in AMKENI. Both organizations had been long-time partners with USAID and with U.S. NGOs working in Kenya. FPAK, as the oldest family planning organization in Africa, set the standard as family planning associations formed across the continent. Prior to the implementation of the Global Gag Rule, FPAK ran 14 conventional family planning clinics providing a broad array of reproductive health care services throughout the country. Some of these clinics also functioned as clinical training sites for the Ministry of Health to train doctors and nurses on how to insert Norplant and IUDs, perform sterilization procedures, and improve the quality of STI/HIV/AIDS counseling. FPAK does not offer abortion services because abortion is illegal in Kenya, but its clinics offer comprehensive post-abortion care (PAC) to women in need of emergency treatment.

MSI Kenya was also a steady recipient of USAID support for many years. From 1998 to 2000, MSI Kenya received \$1.6 million from USAID for training health professionals in contraceptive services and related reproductive health care. MSI Kenya started providing services in 1985, offering women another affordable, private alternative for their reproductive health care. By 2001, MSI Kenya was running 21 clinics throughout the country, providing preventive care (such as Pap smears), screening and treatment for malaria, STIs and tuberculosis, VCT for HIV/AIDS, and infant/child health care such as check-ups, vitamin A tablets, and immunizations. Each MSI Kenya clinic is equipped with a clinical laboratory, enabling clients to get results quickly.

A COSTLY DECISION

The Global Gag Rule took effect in the spring of 2001, just as AMKENI got underway. FPAK and MSI Kenya - the Kenyan NGOs central to AMKENI’s mission — could not accept the policy’s restrictions. Both organizations objected to the Global Gag Rule as a matter of principle and consequently lost U.S. family planning funds. By that summer, **the AMKENI Project team was staring at a gaping hole in service delivery created by the loss of these two NGOs.** Over the next 18 months, AMKENI struggled to identify other Kenyan organizations to fill the gap, while FPAK and MSI Kenya closed clinics and scaled back reproductive health services across the board.

In rejecting the Global Gag Rule, FPAK and MSI Kenya staff cited the ban on counseling and referral as the most problematic and unethical aspect of the policy. **The concept of withholding information from patients contravened their physicians’ and nurses’ medical ethics and moral obligations, as well as violated their patients’ trust and their right to information.** The gag rule’s prohibition of abortion-related advocacy was equally objectionable, given the toll of unsafe abortion on Kenyan women, and the urgent need to address it as a public health matter.

The new conditions imposed on U.S. family planning funds forced FPAK and MSI Kenya into an untenable position: if they agreed to the restrictions, their patients’ health needs and rights would be compromised and their organizational voice silenced. If they rebuffed the conditions, they would forfeit USAID funding and valuable technical assistance (i.e., clinical and management training, quality assurance measures, and other intangibles), which is an enormous loss of resources for both NGOs. Either way, their clients would suffer.

The loss of USAID funds and support was devastating. FPAK was already struggling to operate several clinics that had been heavily subsidized by USAID. (All family planning funds had been reprogrammed to AMKENI by early 2001.) Then the Global Gag Rule took effect, and FPAK forfeited all family planning assistance that came directly from USAID. Their financial dilemma worsened when the International Planned Parenthood Federation (IPPF) headquarters in London also refused to agree to the terms of the policy. Because of this, by 2002 FPAK had lost an additional U.S. \$325,000 in IPPF support. The combined loss of USAID and IPPF funds totaled 58 percent of FPAK’s budget — a huge blow, even for one of Kenya’s oldest and largest health care providers. **MSI Kenya lost U.S. \$600,000 in already-committed USAID funds.** Seemingly overnight, MSI Kenya faced a 40 percent cut in its operating budget and would be hard-pressed to make up the loss quickly from other donors.

CONSEQUENCES OF THE GLOBAL GAG RULE

The departure of both FPAK and MSI Kenya from AMKENI left the project with no obvious substitutes. The government clinics continued participating, since they were not affected by the policy, but they could not realistically be expected to fill the void. Few other Kenyan NGOs possess the geographic presence, national reputation, depth of clinical services, and staff expertise to deliver the same level of quality reproductive health care represented by FPAK and MSI Kenya. EngenderHealth approached other donors for funds to build FPAK and MSI Kenya back into the project but was unsuccessful.

One year later, the AMKENI Project was still cobbling together a loose network of public and private health centers, which AMKENI staff conceded was not on par with the quality and depth of service offered by FPAK and MSI Kenya. **Staff predicted that fewer couples will be reached with health information and services as a result.** At the same time, the loss of USAID funding has compelled both FPAK and MSI Kenya to scale back health care services considerably. The immediate effect of the policy is the erosion of family planning services, which will lead to more unsafe abortion, maternal death and misery for the women of Kenya.

Family planning clinics closed

FPAK and MSI Kenya have each shuttered clinics in densely populated, underserved areas in Nairobi and elsewhere. Collectively, five well-established clinics serving tens of thousands of women have closed. In many instances, FPAK and MSI Kenya clinics were the only source of affordable primary health care in these areas.

FPAK has closed three clinics to date and laid off 30 percent of its staff. All three clinics had been supported entirely by the USAID Mission in Kenya prior to 2001, and each clinic had recently started offering PAC services. Collectively in 2000, these clinics served nearly 19,000 clients — roughly 1,560 women, men and children every month. The three services that closed were:

- The Embu Town clinic, which was established in 1978 in the provincial capital of Kenya's eastern province north of Nairobi, provided STI testing and treatment, pre- and post-natal obstetric care, and well-baby care. This clinic also ran an outreach program that provided health information, HIV prevention, contraception and referrals to thousands of rural women.
- FPAK's Kisii clinic, which opened in 1985 in a densely populated town in Nyanza province in Kenya's vast rural western region. **The clinic served as a regional training center for doctors and nurses learning tubal ligation and vasectomy procedures, and Norplant insertion and removal.** Clinicians from both the private and public sectors received training at the Kisii clinic. Prior to its closure, FPAK had plans to upgrade and expand the clinic to provide more services.
- The Eastleigh clinic is in a crowded slum neighborhood of Nairobi, where FPAK started offering desperately needed reproductive health care in 1984. There are no government-run health clinics in Eastleigh. STI screening and treatment, family planning, pre- and post-natal obstetric services, and well-baby care were the services most in demand among its clients.

MSI Kenya had closed two of its clinics by September, 2001. After laying off one-fifth of its staff, cutting salaries, increasing client fees, and completely reorganizing its clinic structure, MSI Kenya was able to avoid closing seven additional clinics and one maternity nursing home. **Reproductive health services had been heavily subsidized at the clinics that closed,** with MSI Kenya frequently providing free care to many of the women who could not afford to pay. These closed clinics, which had served the poorest of the poor, were:

- The Mathare Valley clinic, which was established in 1987 in a vast slum neighborhood of Nairobi. It was the first and only health facility for this compound of 300,000 people for 10 years. In 1998, the NGO Doctors Without Borders opened a primary health care clinic in Mathare Valley, intentionally locating it next door to the MSI Kenya clinic to give residents maximum access to health services. **The MSI Kenya clinic provided basic services — Pap smears, family planning, STI screening and treatment, HIV testing and counseling, post-abortion care — which women simply couldn't get anywhere else.** The loss of this MSI Kenya clinic has severely affected the women of Mathare Valley. Women there seldom leave the neighborhood, and would not seek health care elsewhere unless it were an emergency. Given the closure of the MSI Kenya clinic, women cited lack of time and transportation as the main reasons they would forgo family planning and related preventive care.
- Kisumu, the third largest town in Kenya, is the provincial capital of Nyanza Province where HIV prevalence is highest. The MSI Kenya clinic there served approximately 400 women each month. In addition to providing traditional clinic-based health services, including HIV/AIDS services, the Kisumu clinic supported a team of community health workers to deliver care to women living too far away to reach the clinic on a regular basis.

Access to family planning eroded

Beyond the clinic closures, FPAK and MSI Kenya have had to scale back family planning services in the rest of their clinics. The loss of USAID support caused both organizations to lay off many experienced staff, cut salaries and raise fees. Consequently, **the remaining personnel are underpaid and overworked, providing care to fewer patients on a daily basis than before the Global Gag Rule was reinstated.** FPAK staff commented that their remaining clinics are functioning with the absolute minimum of staff needed to keep doors open and services flowing. They reported that overall morale has never been lower. The staff recognize that higher fees instituted by FPAK and MSI Kenya beginning in 2001 have caused many women to forgo family planning and related health care. Few can afford to pay, given the state of Kenya's economy.

Meanwhile, **the capacity of the AMKENI Project to expand access to family planning and increase couples' contraceptive options is severely challenged** without the participation of FPAK and MSI Kenya. Both organizations were set to carry out the bulk of AMKENI's community outreach — dispensing contraception, disseminating family planning and HIV/AIDS information, and making medical referrals to people beyond the reach of the nearest clinic. Replacing FPAK and MSI Kenya clinics with other, comparable facilities cannot happen easily or quickly; thus thousands of couples now receive services later than they would have, or not at all.

Level of maternal and child health care reduced

FPAK and MSI Kenya clinics are important providers of prenatal and postnatal obstetric care, especially in rural areas. In most clinics, women are routinely offered immunizations, malaria tablets, and vitamin A supplements for their infants and children. The magnitude of the staff and funding cuts has meant that even pregnancy- and infant-related care are scaled back, and there are fewer community health workers to provide care to women in hard-to-reach areas.

FPAK's now-closed Embu clinic housed a well-baby center that provided comprehensive infant care. Its loss means that the diverse population of urban and rural women served by the clinic is now deprived of a valued source of health care. All 19 MSI Kenya clinics continue to offer prenatal care and basic infant health services, yet their capacity to do so is reduced and fees have gone up. MSI Kenya's four maternity centers — all located in rural areas and providing safe delivery and related obstetric services — had been set to close by the end of 2001. Only an immediate and massive internal reorganization by MSI Kenya ensured their continued operation.

At the MSI Kenya maternity center in Murang'a, a hilly rural town about one hour north of Nairobi, the team conducting the research for this report interviewed several women who were there to visit a friend who had just given birth. The women, all of whom had delivered their babies at this mini-hospital over the years, declared they would not voluntarily go to the nearest public hospital for even the slightest ailment. At the MSI maternity center, they explained, patients are treated with respect; there are no long waits for appointments; medical supplies never run out; test results are prompt; and the facilities are tidy and in excellent repair — compared to the government hospital nearby. Even though their care at the government hospital would be free of charge, the women were determined to find the necessary funds to pay for health care that offered them respect and clean surroundings.

Community-based distribution cut back

Over the years, both FPAK and MSI Kenya had expanded to provide community-based distribution (CBD) of family planning information and services — work that USAID funded heavily. In 1982, Kenya had no CBD effort to speak of; by 1989, Kenya boasted a strong CBD program, and the reproductive health needs of rural women began to be fulfilled.¹² Kenya's remarkable success with CBD is primarily due to steadfast support from USAID. The CBD strategy is a hallmark of USAID family planning assistance throughout Africa — it is extremely cost-effective, and is often the strongest link with hard-to-reach communities, such as slum areas and rural villages.

The CBD agents typically dispense condoms and contraceptive pills, and counsel and refer clients for related maternal and child health services. Increasingly, CBD serves as a platform for spreading information about HIV/AIDS prevention, the importance of knowing one's HIV status, where to get tested, and referrals for clinic-based services. MSI Kenya staff reported that their community health workers are equally popular with women and men, and can often be found providing home-based care for patients suffering from HIV/AIDS.

The Global Gag Rule has drastically curtailed the CBD programs of FPAK and MSI Kenya, which were central to the success of AMKENI. FPAK cut its CBD agents by 50 percent and reported difficulty in furnishing their remaining health workers with adequate supplies of contraceptives. MSI Kenya's outreach program has been similarly devastated. **Kenyan women's success in using contraception to plan their families can be largely attributed to CBD efforts of both organizations, which were supported by USAID for years. Many health providers expressed concern that without consistent, well-staffed CBD programs, recent gains in maternal and child health may begin to slip — particularly in rural areas.**

Access to long-acting and permanent contraception diminished

Women's access to Depo-Provera (an injectable hormonal contraceptive), sterilization, IUD and Norplant (hormonal implants) has been disrupted significantly since FPAK and MSI Kenya closed clinics, scaled back services, and reduced their clinical staff. Fees have increased and staff training in these methods has virtually ceased within both organizations at a time when these methods are becoming increasingly popular.

Among Kenyan women who are currently using modern contraception, Depo-Provera is the most popular method. Its use increased rapidly from 7 percent in 1993 to 12 percent in 1998, making it the predominant method among married women.² Tubal ligation (sterilization) and Norplant are also heavily used by married women. These are important birth control methods for women seeking to space their pregnancies or stop childbearing altogether.

In recent years, Kenyan women have shifted away from depending on government services for their care and, consequently, FPAK and MSI Kenya emerged as primary sources of long-acting and permanent contraception. MSI Kenya clinics alone performed 60 percent of all sterilization procedures (tubal ligation and vasectomy) in the country in 2000.¹³ As partners in AMKENI, select FPAK and MSI Kenya clinics were slated to become "centers of excellence" in the provision of Norplant, Depo-Provera and sterilization services. The clinics would have served as training sites for doctors, nurses and nurse-midwives (from both the public and private sector) at which to gain the necessary technical skills to provide these methods. Health professionals would also have learned techniques for counseling women and men on how to prevent both HIV infection and unwanted pregnancy.

Finding other clinics suitable for training health providers and offering long-term and permanent contraceptive methods has proven difficult for the AMKENI Project. AMKENI staff expressed frustration at having to scrap their original plans, lamenting the considerable time and staff expertise it would require to identify and recruit comparable clinics and turn them into training centers. While AMKENI has made progress since the imposition of the Global Gag Rule, **it is evident that the project's goals of improving women's awareness of, training clinicians to be better providers of, and meeting Kenyan women's growing demand for Depo-Provera, sterilization, Norplant and IUDs have been hindered by the loss of FPAK and MSI Kenya clinics.**

HIV prevention efforts hampered

In Kenya and in the rest of the developing world, HIV/AIDS has rapidly become a major reproductive health issue. Across all age groups HIV infection rates are higher among women than men. With almost half of Kenya's population aged 14 and younger, preventing new HIV infections is paramount. Family planning counseling, STI screening and treatment, and condom distribution are elemental to any HIV prevention strategy and are central to AMKENI's holistic, integrated approach to women's health, child survival and HIV/AIDS prevention.

The loss of Kenya's two most experienced reproductive health organizations has weakened AMKENI's ability to promote and strengthen HIV prevention services in the context of family planning.[†] With all FPAK and MSI Kenya clinics off limits, AMKENI lost the opportunity to expand HIV/AIDS services in these established clinics that would have served thousands of women. Moreover, AMKENI lost access to the legion of community health workers affiliated with both organizations, who are critical to reaching a wider audience. Particularly in the Western province, where HIV prevalence is highest and where AMKENI has a strong regional presence, the Global Gag Rule is inhibiting the widest possible dissemination of HIV prevention information and condoms needed to combat the disease.

The policy has also reduced the capacity of FPAK and MSI Kenya to address HIV/AIDS issues with clients — both male and female. Both organizations are on the front line in combating HIV/AIDS among women and youth, two very vulnerable segments of the population. All MSI Kenya clinics, for example, offer voluntary counseling and testing for HIV/AIDS. Strategies for preventing mother-to-child transmission are employed at each of MSI Kenya's four maternity nursing homes. **Among pregnant women receiving prenatal care at these facilities, staff reported in 2002 that approximately 35 percent tested positive for HIV.** These data augment what government and other private hospitals are gathering in their respective efforts. Collectively, these findings will help guide and refine national strategies for preventing mother-to-child transmission in the years ahead.

The loss of USAID funds and technical support has not caused either organization to cut back drastically any particular HIV-prevention effort, because such efforts are a fundamental aspect of their core family planning activities. Yet the overall cutback in services implemented by FPAK and MSI Kenya has compromised their ability as Kenyan institutions to address an epidemic that is affecting their own country. At a time when the Kenyan government and international donors are dramatically scaling up their response to HIV/AIDS and are coordinating efforts like never before, Kenya's chief reproductive health NGOs are instead reeling from U.S.-imposed funding cuts and scaling back services.

[†] The Global Gag Rule does not technically apply to HIV/AIDS funds from USAID, yet it is hampering HIV prevention efforts. When family planning organizations refuse to accept the terms of the gag rule, STI prevention services (including HIV) and condom supplies that they routinely provide are undermined because of the loss of USAID family planning assistance.

U.S. investment squandered

Kenya's past family planning successes were in large part attributable to consistent USAID leadership and investment over more than two decades. The remarkable decrease in family size — from eight to four children per woman — and the steady rise in contraceptive awareness and use among both women and men would not have been possible without USAID. The technical expertise provided by USAID is unique, as is USAID's commitment to developing the capacity of local NGOs and their staff. Hence, USAID assistance is a genuine investment in sustainability — not just a handout. Other donor agencies typically channel funds through U.N. organizations working in the country or through the Ministry of Health, whereas the USAID approach is to build up local organizations and support private sector health initiatives when appropriate. In this way, U.S. assistance supplements government services while boosting civil society and expanding the marketplace.

By rendering USAID's principal reproductive health NGO partners ineligible for family planning funds, the Global Gag Rule has undermined the effectiveness of U.S. assistance in all areas — maternal and child health, HIV/AIDS, family planning and reproductive health. USAID is unable to collaborate with organizations it determines are the best qualified to deliver integrated services. Fewer Kenyans will obtain needed services. Staff will have to identify other, probably less experienced, NGOs that lack the reputation and name recognition among Kenyan women that made FPAK and MSI Kenya natural allies in the first place.

The AMKENI Project has been well received in the western and coastal provinces. Whether AMKENI will actually achieve its goals is another matter. Certainly the loss of USAID's long-time family planning partners has been a substantial hardship for the project. There is widespread agreement that AMKENI's reach is now shorter than it would have been had FPAK and MSI Kenya continued in the consortium. The Global Gag Rule has hampered USAID's ability to expand and improve women's reproductive health care, and it has undermined years of U.S. investment in the health sector.

UNINTENDED CONSEQUENCES

The story of the Global Gag Rule in Kenya is one of unintended consequences. It has dealt a double blow to the health of Kenyan women: it has crippled USAID's integrated health project and starved the leading family planning NGOs of much-needed funding and technical support. The Global Gag Rule has closed clinics, curtailed family planning and maternal and child health care services, and weakened the collective Kenyan NGO response to HIV/AIDS. "NGO and private sector service delivery points are essential elements of overall provision," asserted a major European donor in laying out a comprehensive strategy for addressing HIV/AIDS.¹⁴ The Global Gag Rule, however, is forcing USAID to embark on an altogether different approach, one that impairs the effectiveness of U.S. development aid.

If the goal of the Global Gag Rule is to ensure separation of abortion-related activities from family planning — in a country where abortion is illegal and causes several thousand injuries and deaths each year — it has sorely missed its mark. The Global Gag Rule has eroded women's access to contraception and reproductive health care. This can only lead to more, not fewer, unsafe abortions and maternal deaths.

IF THE GOAL OF THE GLOBAL GAG RULE is to ensure separation of abortion-related activities from family planning — in a country where abortion is illegal and causes several thousand injuries and deaths each year — it has sorely missed its mark.

Methodology

In addition to the published materials drawn upon for this case study, a number of important interviews served as key sources of information on the impact of the Global Gag Rule in Kenya. The information and personal accounts presented in this report were collected through interviews conducted during two research trips to Kenya, in September 2001 and July 2002, to assess the impact of the Global Gag Rule on family planning and related reproductive health services. The research team interviewed a range of individuals involved in varying aspects of family planning service delivery — program managers, clinic directors, medical and nursing personnel — from both Kenyan and U.S. NGOs. Additionally, numerous clients (patients) were interviewed, as well as staff from international and bilateral donor agencies headquartered in Nairobi. The research team visited several family planning clinics in and around Nairobi to talk with providers and clients, and traveled to health facilities outside of Nairobi, including a district-level public hospital.

¹ Population Reference Bureau (PRB). 2001. 2001 *World Population Data Sheet*. Washington, DC: PRB.

² National Council for Population and Development (NCPD), Central Bureau of Statistics and Office of the Vice President and Ministry of Planning and National Development (Nairobi, Kenya). 1999. *Kenya Demographic and Health Survey (KDHS) 1998*. Calverton, MD: Macro International Inc.

³ The Global Fund to Fight AIDS, Tuberculosis and Malaria. n.d. "Kenya National Proposal to Address and Reduce the Impact of HIV/AIDS, Tuberculosis, and Malaria." Available from <http://www.globfundatm.org/proposals/round2/summarypages/kenya.html>; Internet; accessed 12 August 2003.

⁴ World Health Organization. 2001. "Maternal Mortality in 1995: Estimates developed by WHO, UNICEF, UNFPA." Available from <http://www.who.int/disasters/stats/detail.cfm?indicatorTypeID=137&countryID=64>; Internet; accessed 28 July 2003.

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THE GLOBAL GAG RULE IMPACT PROJECT

is a collaborative research effort led by

Population Action International in partnership with Ipas and Planned Parenthood Federation of America and with assistance in gathering the evidence of impact in the field from EngenderHealth and Pathfinder International.

Recognizing the historic leadership role of the United States in supporting voluntary family planning and related health care internationally, the Project's objective is to document the effects of the Global Gag Rule on the availability of life-saving family planning services, as well as on efforts to address other major threats to public health, including HIV/AIDS and maternal deaths due to unsafe abortion.

From July 2002 to May 2003, research was conducted in four countries: Ethiopia, Kenya, Romania, and Zambia.

The project received its funding solely from private sources.



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